



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Azar Maraghi, D.C.

**Respondent Name**

Bitco National Insurance Company

**MFDR Tracking Number**

M4-17-3535-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 7, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We believe that we have sent the complete billing."

**Amount in Dispute:** \$1,675.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "CorVel determined the medical billing for date of service 06/08/17 was correctly returned to the provider as incomplete based on the signature date preceding the date of service.

Although the billing was appropriately returned to the provider, out of good faith, CorVel will allow reimbursement plus accrued interest in accordance with the division rules since the charges in question are for DD services."

**Response Submitted by:** CorVel

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2017	Designated Doctor Examination	\$1,675.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury performed on or after September 1, 2017.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2017.
4. The submitted documentation does not include explanations of benefits presented to the requestor prior to

the request for medical fee dispute resolution.

### **Issues**

1. Did Bitco Insurance Company maintain its claim of incomplete medical billing?
2. Is Azar Maraghi, D.C. entitled to additional reimbursement?

### **Findings**

1. Bitco Insurance Company returned the medical bills for the services in question stating, "Billed date before date of service," and "NEED COMPLETE BILLING." Submitted documentation includes an Explanation of Review dated August 30, 2017, with a partial payment of \$1,150.00. The division concludes that Bitco Insurance Company did not maintain its claim of incomplete medical billing. Therefore, the merits of this claim will not be reviewed in this dispute.
2. Dr. Maraghi is seeking reimbursement for a designated doctor examination to determine the maximum medical improvement (MMI) and impairment rating (IR) of one body area, and the extent of the compensable injury.

28 Texas Administrative Code §134.250(3) states, in relevant part, "The following applies for billing and reimbursement of an MMI evaluation ... (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be \$350." The documentation submitted supports that Dr. Maraghi performed an examination to determine maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) is \$350.00 for this examination.

28 Texas Administrative Code §134.250(4) states, in relevant part,  
The following applies for billing and reimbursement of an IR evaluation.

(A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form...

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas...

(ii) The MAR for musculoskeletal body areas shall be as follows: ...

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area

The documentation submitted supports that Dr. Maraghi performed an examination to determine the impairment rating and performed a full physical evaluation with range of motion for the cervical spine and left shoulder. Submitted billing indicates that Dr. Maraghi requested reimbursement for one body area. Therefore, the MAR for this examination is \$300.00.

Per 28 Texas Administrative Code §134.235,

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports...

The submitted documentation indicates that Dr. Maraghi performed an examination to determine the extent of the compensable injury. Therefore, the correct MAR for this examination is \$500.00.

The total allowable for the services in question is \$1,150.00. This amount was reimbursed by Bitco Insurance Company. No further reimbursement is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	October 19, 2017 Date
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### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**